Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012007	A. BUILDING: _____ B. WING _____	05/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CROSSING ASSISTED LIVING	2400 MARKET ST CHARLESTOWN, IN 47111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: May 18 and 19, 2015 Facility number: 012007 Provider number: 012007 Aim number: NA Census bed type: Residential: 102 Total: 102 Census payor type: Other: 102 Total: 102 Sample: 12 Supplemental sample: 13 River Crossing Assisted Living was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE